

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **35104**

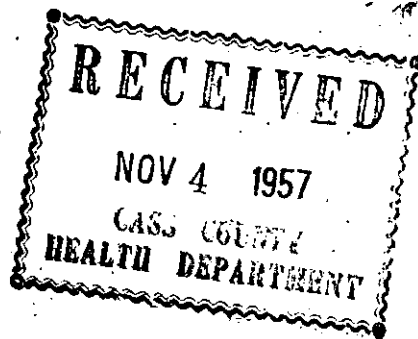
FILED NOV 6 1957

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|---|--|--|--|---|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. 59 | | PRIMARY REG. DIST. NO. 4097 | | Registrar's No. 158 | |
| 1. PLACE OF DEATH a. COUNTY Cass | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cass | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) Harrisonville | | c. LENGTH OF STAY (in this place) 2 days | | c. CITY OR TOWN Harrisonville | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hospital | | | | e. STREET ADDRESS (If rural, give location) 903 S. Independence | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) PEARL M. b. (Middle) YODER c. (Last) _____ | | 4. DATE OF DEATH (Month) Oct (Day) 26 (Year) 1957 | | 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH (Month) July (Day) 17 (Year) 1883 | | 9. AGE (In years last birthday) 74 | | 10. IF UNDER 1 YEAR Months 3 Days 25 Hours 35 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and State or Foreign Country) Gum City Mo | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME Henry Blank | | 13b. MOTHER'S MAIDEN NAME Barbara Yoder | | 14. NAME OF HUSBAND OR WIFE Emery E Yoder | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT'S SIGNATURE OR NAME Mrs Ina King ADDRESS Kansas City Mo | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | 19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion ANTECEDENT CAUSES DUE TO (b) Arteriosclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____ | | | | INTERVAL BETWEEN ONSET AND DEATH 36 hrs. | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21. HOW DID INJURY OCCUR? 4201 | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____ | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____ | |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22. I hereby certify that I attended the deceased from Oct 1951 to Oct 26, 1957 , that I last saw the deceased alive on Oct 26, 1957 , and that death occurred at 10:15 m., from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE Edward S. Jones MD | | 23b. ADDRESS Harrisonville, Mo | | 23c. DATE SIGNED 10-29-57 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE Oct 29-57 | | 24c. NAME OF CEMETERY OR CREMATORY Clear Fork Cemetery | | 24d. LOCATION (City, town, or county) (State) Garden City, Mo | |
| DATE REC'D BY LOCAL REG. Oct 29 1957 | | REGISTRAR'S SIGNATURE Dora Barnard | | 25. FUNERAL DIRECTOR'S SIGNATURE A. D. Hartzler ADDRESS East Lynne Mo | | | |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

VS NOV 25 1952



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
A. D. Warkles

Licensed Embalmer No. 2717
P. O. Address East Lyme

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.